

Any member of staff who agrees to accept responsibility for administering prescribed medicines for a child should have appropriate training and guidance. They should also be aware of possible side effects of the medicines and what to do if they occur. The type of training necessary will depend on the individual case.

Teachers' conditions of employment do not include giving or supervising a pupil taking medicines. The Governing Body acknowledges that it should ensure there are sufficient members of support staff employed and appropriately trained to manage medicines as part of their duties.

Any member of staff who agrees to accept responsibility for administering prescribed medicines for a child should have appropriate training and guidance. They should also be aware of possible side effects of the medicines and what to do if they occur. The type of training necessary will depend on the individual case.

If the administration of prescription medicines requires technical or medical knowledge then individual training should be provided to staff from a qualified health professional. Training is specific to the individual child concerned.

It should be noted by parents and carers that they should keep children at home when they are acutely unwell.

The Head teacher will need to agree with a child's parents or carers exactly what support can be provided. Where parents' and carers' expectations appear unreasonable the Head teacher should seek advice from the school nurse or doctor, the child's GP or other medical advisers and, if appropriate, from the Governing Body.

Staff having children with medical needs in their class or group should be informed about the nature of the condition and when and where the children may need extra attention. The child's parents or carers and health professionals should provide this information to the school.

All medicines may be harmful to anyone for whom they are not appropriate.

Large volumes of medicines are not to be stored at Raine's Foundation School.

Medicines should be stored strictly in accordance with product instructions (paying particular note to any temperature requirements for storage). They must be kept in the original containers in which they were dispensed.

Staff should ensure that the supplied container is clearly labelled with the name of the child, the name and does of the medicine and the frequency of administration. This should be easy if medicines are only accepted in their original container as dispensed by a pharmacist in accordance with the prescriber's instructions.

Staff should only store, supervise and administer medicine that has been prescribed for an individual child. Where a child needs two or more prescribed medicines, each should be in a separate container. Non-healthcare staff should never transfer medicines from their original containers.

Children should know where their own medicines are stored and who holds any key to them.

The Head teacher is responsible for making sure that medicines are stored safely. All **EMERGENCY** medicines, such as **ASTHMA INHALERS** and **ADRENALINE PENS ("EPI-PENS")** should be readily available to children **and should not be locked away.**

Many schools allow children to carry their own inhalers and this should be considered on an individual basis.

Other non-emergency medicines should generally be kept in a secure place not accessible to children.

A few medicines need to be refrigerated. They can be kept in a refrigerator containing food but should be in an airtight container and clearly labelled. There should be restricted access to a refrigerator which is holding medicines.

Access to medicines

Children need to have immediate access to their medicines when required - particularly the sort of emergency medicines mentioned earlier. However, it is important to make sure that medicines are only accessible to those for whom they are prescribed.

Disposal of medicines

Staff should not dispose of medicines. Parents and carers are responsible for ensuring that date-expired medicines are returned to a pharmacist for safe disposal.

Sharps boxes should always be used for disposal of needles. Sharps boxes can be obtained by parents and carers on a prescription from the child's GP or paediatrician. Collection and disposal of such boxes should be arranged with the local authority's environmental services department.

Hygiene and infection control

All staff should be familiar with normal precautions for avoiding infection and follow basic hygiene procedures. Staff should have access to protective disposable gloves and take care when dealing with spillages of blood or other body fluids and disposing of dressings and equipment.

Emergency procedures

As part of general risk management processes the Head teacher should ensure that arrangements are in place for dealing with emergency situations and providing appropriate first aid.

Children themselves should know what to do in the event of an emergency, such as informing a member of staff.

All staff should know how to contact the emergency services.

All staff should be aware of who is responsible for carrying out emergency procedures in the event of need.

A member of staff should always accompany a child taken to hospital by ambulance and should stay until the child's parent or carer arrives. Health professionals are responsible for any decisions on medical treatment when parents and carers are not available.

Staff should only take children to hospital in their own car ***if it is absolutely necessary***, it is safer to call an ambulance.

Individual healthcare plans should include instructions as to how to manage a child in an emergency, and identify who has responsibility in an emergency. For example, if there is an incident in the playground a lunchtime supervisor would need to be very clear as to their role.

Healthcare plans

The main purpose of an individual healthcare plan for a child with medical needs is to identify the level of support that is required. Not all children who have medical needs will require an individual plan.

A written healthcare plan clarifies for staff, parents, carers and the child what help can be provided at school. It is important for staff to be guided by the child's GP or paediatrician. The School Health Team normally develops and reviews healthcare plans with parents and carers. It is sensible to carry out reviews at least once a year, but much depends on the nature of the child's particular needs; some plans may need reviewing more frequently.

Staff should judge each child's needs individually as children and young people vary in their ability to cope with poor health or a particular medical condition.

Developing a healthcare plan should not be onerous, although each plan will contain different levels of detail according to the needs of the individual child.

In addition to input from school health services, the child's GP or other healthcare professionals (depending on the level of support the child needs) those who may need to contribute to a healthcare plan include:

- The Head teacher
- The parent or carer
- The child (if appropriate)
- Form tutor
- Head of Year
- Care assistant or support staff
- Staff who are trained to administer medicines
- Staff who are trained in emergency procedures

Co-ordinating information

Co-ordinating and sharing information on an individual pupil with medical needs, particularly in a secondary school, can be difficult.

The Head teacher should decide which member of staff has specific responsibility for this role. The person should be the first contact for parents, carers and staff and liaise with external agencies, such as the school nurse or relevant paediatrician.

It would be helpful if members of staff with this role attended training on managing medicines. Local authorities' regional consortia and others provide such training.

Information for staff and others

Staff who need to deal with an emergency will need to know about a child's medical needs. The Head teacher should make sure that supply staff are also made aware of the medical needs of any children in their class. When a child is added to the school roll, up-to-date information on any relevant medical condition should be recorded.

Off-site education or work experience

Schools are responsible for ensuring, under an employer's overall policy, that work experience placements are suitable for pupils with medical needs.

As a consequence, consideration should be given as to whether it is necessary to carry out a risk assessment before a young person is educated off-site or undertakes work experience. There may also be a need to check a young person's immunisation status (e.g. for Diphtheria, Tetanus and Polio) where the work could involve contact with animals or soil.

Staff training

In developing healthcare plans it may become apparent that some staff will require additional information about a medical condition, such as specific training to administer a particular type of medicine or to deal with emergencies arising from it.

When members of staff agree to help a child with medical needs, appropriate training should be arranged. The School Health Team provides training and staff may need to update their knowledge and skills at regular intervals, such as every six months or annually.

Confidentiality

The Head teacher and staff should always treat medical information confidentially. The Head teacher should agree with the child, where appropriate, or otherwise the parent/carer, who else should have access to records and other information about a child. If information is withheld from staff they should not generally be held responsible if they act incorrectly in giving medical assistance but otherwise in good faith.

Common conditions – practical advice on Asthma, Epilepsy, Diabetes, Anaphylaxis and Eczema

The medical conditions in children that most commonly cause concern in schools are

- Asthma
- Diabetes
- Epilepsy
- Severe allergic reaction (Anaphylaxis) and
- Eczema

The following is some basic information about these conditions

Asthma

What is asthma?

Asthma is common and appears to be increasingly prevalent in children and young people. One in ten children has asthma in the UK. The most common symptoms of asthma are coughing, wheezing or whistling noise in the chest, tight feelings in the chest or getting short of breath.

Younger children may verbalise this by saying that their tummy hurts or that it feels like someone is sitting on their chest. Not everyone will get all these symptoms, and some children may only get symptoms from time to time.

Medicine and control

There are two main types of medicines to treat asthma – “relievers” and “preventers”. Usually a child will only need a reliever during the school day. Relievers (blue inhalers) are medicines taken immediately to relieve asthma symptoms and are taken during an asthma attack. They are sometimes taken before exercise.

Preventers (brown, red or orange inhalers; sometimes tablets) are usually used out of school hours.

Children with asthma need to have immediate access to their reliever inhalers when they need them. Inhaler devices usually deliver asthma medicines. A spacer device may be used with a child’s inhaler. The child might need some help with it.

It is good practice to support children with asthma to take charge of and use their inhaler from an early age, and many do.

Children who are able to use their inhalers themselves should be allowed to carry them with them. If the child is too young or immature to take personal responsibility for their inhaler, staff should make sure that it is stored in a safe, but readily accessible place, and is clearly marked with the child’s name and pharmacy instructions.

Inhalers should always be available during physical education (PE), sports activities and educational visits.

For a child with severe asthma, the healthcare professional may prescribe a spare inhaler to be kept in the school.

The signs of an asthma attack include:

- Coughing
- Being short of breath
- Wheezy breathing
- Feeling of tight chest
- Being unusually quiet

When a child has an asthma attack they should be treated according to their individual healthcare plan or asthma card, as previously agreed.

An ambulance should be called if

- The symptoms do not improve sufficiently in 5-10 minutes
- The child is too breathless to speak
- The child is becoming exhausted
- The child looks blue

It is important to agree with parents and carers or children with asthma how to recognise when their child's asthma gets worse and what action will be taken. An Asthma School Card (available from Asthma UK) is a useful way to store written information about the child's asthma and should include details about asthma medicines, triggers, individual symptoms and emergency contact numbers for the parent, carer and child's doctor.

A child should have a regular asthma review with their GP or other relevant healthcare professional. Parents and carers should arrange the review and make sure that a copy of their child's management plan is available to the school. Children should have a reliever inhaler with them when they are in school.

Children with asthma should participate in all aspects of the school day including physical activities. They need to take their reliever with them on all off-site activities. Physical activity benefits children with asthma in the same way as other children. Swimming is particularly beneficial, although endurance work should be avoided. Some children may need to take their reliever asthma medicines before any physical

exertion. Warm-up activities are essential before any sudden activity, especially in cold weather. Particular care may be necessary in cold or wet weather.

Reluctance to participate in physical activities should be discussed with parents, carers, staff and the child. However, children with asthma should not be forced to take part if they feel unwell. Children should be encouraged to recognise when their symptoms inhibit their ability to participate.

Children with asthma may not attend on some days due to their condition, and may also at times have some sleep disturbances due to night symptoms. This may affect their concentration. Such issues should be discussed with the child's parents/carers or attendance officer, as appropriate.

The school environment should be asthma friendly, by endeavouring to remove as many potential triggers as possible.

All staff, particularly PE teachers, should have training or be provided with information about asthma. This should support them to feel confident about recognising worsening symptoms of asthma, knowing about asthma medicines and their delivery and what to do if a child has an asthma attack.

Epilepsy

What is epilepsy?

Children with epilepsy have repeated seizures that start in the brain. An epileptic seizure, sometimes called a fit, turn or blackout, can happen to anyone at any time.

Seizures can happen for many reasons. At least one in 200 children has epilepsy and around 80% of them attend mainstream schools. Most children with diagnosed epilepsy never have a seizure during the school day. Epilepsy is a very individual condition.

Seizures can take many different forms and a wide range of terms may be used to describe the particular seizure pattern that individual children experience. Parents and healthcare professionals should provide information to the school, to be incorporated into the individual healthcare plan, setting out the particular pattern of

an individual child's epilepsy. If a child does experience a seizure in school, details should be recorded and communicated to parents/carers including

- Any factors which might possibly have acted as a trigger to the seizure, e.g. visual/auditory stimulation, emotion (anxiety, upset)
- Any unusual "feelings" reported by the child prior to the seizure
- Parts of the body demonstrating seizure activity, e.g. limbs or facial muscles
- The timing of the seizure – when it happened and how long it lasted
- Whether the child lost consciousness
- Whether the child was incontinent

This will help parents/carers to give more accurate information on seizures and seizure frequency to the child's specialist.

What the child experiences depends whether all or which part of the brain is affected. Not all seizures involve loss of consciousness. When only a part of the brain is affected, a child will remain conscious with symptoms ranging from the twitching or jerking of a limb to experiencing strange tastes or sensations such as pins and needles. Where consciousness is affected; a child may appear confused, wander around and be unaware of their surroundings. They could also behave in unusual ways, such as plucking at clothes, fiddling with objects or making mumbling sounds and chewing movements. They may not respond if spoken to. Afterwards they may have little or no memory of the seizure.

In some cases the seizures go on to affect all of the brain and the child loses consciousness. Such seizures might start with the child crying out, and then the muscles becoming stiff and rigid. The child may fall down. Then there are jerking movements as muscles relax and tighten rhythmically. During a seizure breathing may become difficult and the child's colour may change to a pale blue or grey colour around the mouth. Some children may bite their tongue or cheek and may wet themselves.

After a seizure a child may feel tired, be confused, have a headache and need time to rest or sleep. Recovery times vary. Some children feel better after a few minutes while others may need to sleep for several hours. A child might require a quiet space in which to recover.

Another type of seizure affecting all of the brain involves a loss of consciousness for a few seconds. A child may appear “blank” or “staring” sometimes with fluttering of the eyelids. Such absence seizures can be so subtle that they may go unnoticed. They might be mistaken for daydreaming or not paying attention in class. If such seizures happen frequently they could be a cause of deteriorating academic performance.

Medicine and control

Most children with epilepsy take anti-epileptic medicines to stop or reduce their seizures. Regular medicine should not need to be given during school hours. Triggers such as anxiety, stress, tiredness or being unwell may increase a child's chances of having a seizure. Flashing and flickering lights and some geometric shapes or patterns can also trigger seizures. This is called “photosensitivity”. It is very rare. Most children with epilepsy can use computers and watch television without any problem.

Children with epilepsy should be included in all activities. Extra care may be needed in some areas, such as swimming or working in science laboratories. Concerns about safety should be discussed with the child and parents/carers as part of the healthcare plan.

During a seizure it is important to make sure the child is in a safe position, not to restrict a child's movements and to allow the seizure to take its course. In a convulsive seizure putting something soft under the child's head will help to protect it. Nothing should be placed in their mouth. After a convulsive seizure has stopped, the child should be placed in the recovery position and stayed with until they're fully recovered.

An ambulance should be called during a convulsive seizure if

- It is the child's first seizure
- They have injured themselves badly
- They have problems breathing after the seizure
- A seizure lasts longer than the period set out in the child's healthcare plan
- A seizure lasts for five minutes if you do not know how long they usually last for that child

- There are repeated seizures, unless this is normal for the child as set out in the child's healthcare plan

The child's healthcare plan should clearly identify the type or types of seizures, including seizure descriptions, possible triggers and whether emergency intervention may be required.

Most seizures last for a few seconds or minutes and stop of their own accord. Some children who have longer seizures may be prescribed *buccal midazolam* or *diazepam* for rectal administration. Buccal midazolam is a drug used to stop seizures. This is an effective emergency treatment for prolonged seizures. The epilepsy nurse or a paediatrician should provide guidance as to when to administer it and why.

The School Health Team provides training in the administration of rectal diazepam. Staying with the child afterwards is important as diazepam may cause drowsiness.

Children and young people requiring rectal diazepam will vary in age, background and ethnicity and will have different levels of need, ability and communication skills. If arrangements can be made for two adults, at least one of the same gender as the child, to be present for such treatment, this minimises the potential for accusations of abuse. Two adults can often ease practical administration of treatment. Staff should protect the dignity of the child as far as possible – even in emergencies.

Diabetes

What is diabetes?

Diabetes is a condition where the level of glucose in the blood rises. This is either due to the lack of insulin (Type 1 diabetes) or because there is insufficient insulin for the child's needs or the insulin is not working properly (Type 2 diabetes).

About one in 550 school-age children have diabetes. The majority of children have Type 1 diabetes. They normally need to have daily insulin injections, to monitor their blood glucose level and to eat regularly according to their personal dietary plan.

Children with Type 2 diabetes are usually treated by diet and exercise alone.

Each child may experience different symptoms and this should be discussed when drawing up the healthcare plan. Greater than usual need to go to the toilet or to drink, tiredness and weight loss may indicate poor diabetic control and staff will naturally wish to draw any such signs to parents' and carers' attention.

Medicine and control

The diabetes of the majority of children is controlled by injections of insulin each day. Most younger children will be on a twice a day insulin regime of a longer acting insulin and it is unlikely that these will need to be given during school hours, although for those who do it may be necessary for an adult to administer the injection.

Older children may be on multiple injections and others may be controlled on an insulin pump. Most children can manage their own injections, but if doses are required at school, supervision may be required, and also a suitable, private place to carry it out.

Increasingly, older children are taught to count their carbohydrate intake and adjust their insulin accordingly. This means that they have a daily dose of long-acting insulin at home, usually at bedtime; and then insulin with breakfast, lunch and the evening meal, and before substantial snacks. The child is taught how much insulin to give with each meal, depending on the amount of carbohydrate eaten. They may or may not need to test blood sugar prior to the meal and to decide how much insulin to give.

Diabetic specialists would only implement this type of regime when they were confident that the child was competent. The child is then responsible for the injections and the regime would be set out in the individual healthcare plan.

Children with diabetes need to ensure that their blood glucose levels remain stable and may check their levels by taking a small sample of blood and using a small monitor at regular intervals. They may need to do this during the school lunch break, before PE or more regularly if their insulin needs adjusting. Most older children will be able to do this themselves and will simply need a suitable place to do so. However, younger children may need adult supervision to carry out the test and/or interpret the results.

When staff agree to administer blood glucose tests or insulin injections they should be trained by an appropriate healthcare professional.

Children with diabetes need to be allowed to eat regularly during the day. This may include eating snacks during class time or prior to exercise. Special arrangements may need to be made to cope with staggered lunch breaks. If a meal or snack is missed, or after strenuous activity, the child may experience a hypoglycaemic episode (a “hypo”).

During such an episode blood glucose levels fall too low. Staff in charge of PE or other physical activity sessions should be aware of the need for children with diabetes to have glucose tablets or a sugary drink to hand.

Staff should be aware that the following symptoms, either individually or combined may be indicators of low blood sugar – a hypoglycaemic reaction – in a child with diabetes

- Hunger
- Sweating
- Drowsiness
- Pallor
- Glazed eyes
- Shaking or trembling
- Lack of concentration
- Irritability
- Headache
- Mood changes – especially anger or aggressive behaviour

Each child may experience different symptoms and this should be discussed when drawing up a healthcare plan.

If a child has a “hypo” it is very important that the child is not left alone and that a fast acting sugar, such as glucose tablets, a glucose rich gel or a sugary drink is brought for the child and given immediately. Slower acting starchy foods, such as a sandwich or two biscuits and a glass of milk should be given once the child has recovered, some 10-15 minutes later.

An ambulance should be called if:

- The child's recovery takes longer than 10-15 minutes
- The child becomes unconscious

Some children experience "hyperglycaemia" (high glucose level) and have a greater than usual need to go to the toilet or to drink. Tiredness and weight loss may indicate poor diabetic control and staff will naturally wish to draw any such signs to parents'/carers' attention. If the child is unwell, vomiting or has diarrhoea, this can lead to dehydration. If the child is giving off a smell of pear drops or acetone this may be a sign of ketosis and dehydration and the child will need urgent medical attention.

Anaphylaxis

What is anaphylaxis?

Anaphylaxis is an acute, severe allergic reaction requiring immediate medical attention. It usually occurs within seconds or minutes of exposure to a certain food or substance, but on rare occasions may happen after a few hours.

Common triggers include:

- Peanuts
- Tree nuts
- Sesame
- Eggs
- Cow's milk
- Fish
- Certain fruits, such as Kiwi Fruit
- Penicillin
- Latex
- The venom of stinging insects, such as bees, wasps and hornets

The most severe form of allergic reaction is "anaphylactic shock", when the blood pressure falls dramatically and the patient loses consciousness. Fortunately this is rare among young children below teenage years. More commonly among children there may be swelling in the throat, which can restrict the air supply, or severe asthma. Any symptoms affecting the breathing are serious.

Less severe symptoms may include tingling or itching in the mouth, hives anywhere on the body, generalised flushing of the skin or abdominal cramps, nausea and vomiting.

Even where mild symptoms are present, the child should be watched carefully. They may be heralding the start of a more serious reaction.

Medicine and control

The treatment for a severe allergic reaction is an injection of adrenaline (also known as epinephrine). Pre-loaded devices (such as “Epi-Pens”) containing one measured dose of adrenaline are available on prescription. The devices are available in two strengths – adult and junior.

Should a severe allergic reaction occur, the adrenaline injection should be administered into the muscle of the upper thigh.

An ambulance should always be called. Any used injection device should accompany the child to hospital in a container.

Staff that volunteer to be trained in the use of these devices can be reassured that they are simple to administer. Adrenaline injectors, given in accordance with the manufacturer’s instructions, are a well-understood and safe delivery mechanism. It is not possible to give too large a dose using this device. The needle is not seen until after it has been withdrawn from the child’s leg. In case of doubt it is better to give the injection than to hold back.

The decision on how many adrenaline devices the school should hold and where to store them has to be decided on an individual basis between the Head teacher, the child’s parents/carers and medical staff involved.

Where children are considered to be sufficiently responsible to carry their emergency treatment on their person, there should always be a spare set kept safely, which is not locked away and is accessible to all staff.

As Raine's Foundation School is on split sites it is often quicker for staff to use an injector that is with the child, rather than taking time to collect one from a central location.

Studies have shown that the risks for allergic children are reduced when an individual healthcare plan is in place. Reactions become rarer and when they occur they are mostly mild. The plan will need to be agreed by the child's parents/carers, the school and the treating doctor.

Important issues specific to anaphylaxis to be covered include:

- What may trigger a reaction
- What to do in an emergency
- Prescribed medicine
- Food management
- Precautionary measures

Once staff have agreed to administer medicine to an allergic child in an emergency a training session will need to be provided by the School Health Team. Staff should have the opportunity to practise with trainer injection devices.

Day to day policy measures are needed for food management, awareness of the child's needs in relation to the menu, individual meal requirements and snacks in school. When kitchen staff is employed by a separate organisation, it is important to ensure that the catering supervisor is fully aware of the child's particular requirements. A "kitchen code of practice" could be put in place, for example.

Parents often ask the Head teacher to exclude from the school premises the food to which their child is allergic. This is not always feasible, although appropriate steps to minimise any risks to allergic children should be taken.

Children who are at risks of severe allergic reaction are not ill in the usual sense. They are normal children in every respect – except that if they come into contact with a certain food or substance they may become very unwell. It is important that these children are not stigmatised or made to feel different. It is important too, to allay parents' and carers' fears, by reassuring them that prompt and efficient action will be taken in accordance with medical advice and guidance.

Anaphylaxis is manageable. With sound precautionary measures and support from the staff, school life may continue as normal for all concerned.

Eczema

What is eczema?

Eczema (also known as dermatitis) is a dry skin condition. It is a highly individual condition which varies from person to person and comes in many different forms. **It is not contagious** so you cannot catch it from someone else. This should be understood by all staff and may need to be emphasised to students.

In mild cases of eczema the skin is dry, scaly, red and itchy. In more severe cases there may be weeping, crusting and bleeding. Constant scratching causes the skin to split and bleed and also leaves it open to infection.

Eczema affects all ages, but is primarily seen in children. Those who grow out of their eczema during early childhood may see it recur again in later life.

In the UK one in five children has eczema. Atopic eczema is a genetic condition based on the interaction between a number of genes and environmental factors. In most cases there will be a family history of either eczema or one of the other “atopic” conditions, i.e. asthma or hay fever.

About our skin

To understand what eczema is and what causes it, it helps to know something about the differences between healthy skin and skin affected by eczema.

Our skin provides a strong, effective barrier that protects the body from infection and irritation. Skin is made up of a thin outer layer, a fairly elastic one in the middle, and a fatty layer at the deepest level. Each layer contains skin cells, water and fats, all of which help to maintain and protect the condition of the skin.

Healthy skin

Healthy skin cells are plumped up with water, forming a protective barrier against damage and infection. Fats and oils in the skin help retain moisture, maintain body temperature and also prevent harmful substances or bacteria from entering our bodies.

One way of picturing the way skin works is by thinking of it as a brick wall. The outer skin cells are the bricks, while the fats and oils act as the mortar that keeps everything together, and acts as a seal. The skin cells attract and keep water inside and the fats and oils also keep the water in.

Barrier function in eczematous skin

The skin of a person with eczema may not produce as much fats and oils as other people's and it will be less able to retain water. The protective barrier is therefore not as good as it should be. Gaps open up between the skin cells because they are not sufficiently plumped up with water. Moisture is then lost from the deeper layers of the skin allowing bacteria and irritants to pass through more easily.

Some everyday substances contribute to breaking down the skin. Soap, bubble bath and washing-up liquid, for example, will remove oil from anyone's skin, but if you have eczema your skin breaks down more easily, quickly becoming irritated, cracked and inflamed.

Because it is prone to drying out and is easily damaged, skin with eczema is more liable to become red and inflamed in contact with substances that are known to irritate or cause an allergic reaction.

Treatment

Keeping skin moisturised using emollients (medical moisturisers in the form of creams, ointments, lotions and gels) is key to managing all types of eczema, with topical steroids commonly used to bring flare ups under control.

Antihistamine tablets are sometimes tried to help ease itchiness, but they may cause drowsiness.

Moisturisers and appropriate clothing (often made from cotton) can normally be put on at home. If itching becomes a problem, reference to the school nurse may be necessary.

Common Law duty of care

Anyone caring for children, including teachers and other school staff in charge of children has a common law duty of care to act like any reasonably prudent parent.

Staff need to make sure that children are healthy and safe. In exceptional circumstances the duty of care could extend to administering medicine and/or taking action in an emergency. This duty also extends to staff leading activities taking place off-site, such as visits, outings or field trips.

School admissions etc.

Children with medical needs have the same rights of admission to school as other children and cannot generally be excluded from school for medical reasons. Where a pupil's presence on the school site represents a serious risk to the health and safety of other pupils or school staff the Head teacher may send the pupil home that day after consultation with the parents or carers. This is not an exclusion and may only be done for medical reasons.

Most schools will at some time have children on roll with medical needs. The responsibility of the Governing Body is to make sure that safety measures cover the needs of all children at the school. This may mean making special arrangements for particular children.

In some cases children with medical needs may be more at risks than other children. Staff may need to take additional steps to safeguard the health and safety of such children. In a few cases, individual procedures may be needed. The Governing Body is responsible for making sure that all relevant staff know about and are, if necessary trained to provide any additional support these children require.

Medical accommodation

The Education (School Premises) Regulations 1999 require every school to have a room appropriate and readily available for use for medical or dental examination or treatment and for the caring of sick or injured pupils.

Any child placed in such a room needs to be constantly monitored by a member of staff.